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The RHODE ISLAND MEDICAL JOURNAL

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CARCINOMA OF THE ENDOMETRIUM

GEORGE W. WATERMAN, M.D., F.A.C.S.

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At the Tumor Clinic of the Rhode Island Hospital we have the records of 140 cases of Cancer of the Endometrium on file from 1924 to 1942 inclusive. The 140 records represent consecutive cases seen at the Clinics or in private practice, and include all cases treated or untreated or who received their primary treatment elsewhere and were later admitted to our service for treatment.

As many of these patients were private cases of Dr. Herman C. Pitts, our former Chief-of-Service, I wish to acknowledge his permission to include them, and to thank him for his continued interest and inspiration and for his help in the follow-up of these cases.

Eighty of this series of 140 were treated between 1924 and 1938, and have been followed for five or more years. It is with these 80 cases that this report is mostly concerned. In a special study of 48 hysterectomy specimens after radium treatment, to be presented as part of this report, many of the cases not requiring follow-up are taken from the list of those treated later than 1938.

The purpose of this study, which is the first to be undertaken by us on this subject, is to take account of stock; first to ascertain general factors, i. e. (1) marital state, (2) gravidity, (3) age incidence, (4) symptomatology, (5) associated pathology; second, to study the type of cases that were coming to our Clinic, whether early or late, and in what proportions; third, to determine the so-called grade malignancy as shown by microscopic structure and kind of cell predominating the picture; fourth, to find out what our five year survival rates are, how they compare with the rates published by others for similar series of cases, and to what extent stage of advancement of the growth and grade of malignancy of tissue plays a part in prognosis; to take up the problem of treatment, to see where our best results have occurred, whether with radium alone, surgery alone, or with a combination of radium followed by surgery; fifth, as a special

problem, we have studied through the cooperation of Dr. B. Earl Clarke, Chief of the Pathology Department, 48 hysterectomy specimens to see how effective preliminary radium treatment has been in ridding the uterus of cancer cells, in order that we may from our own experience better decide to what extent we may be justified in depending upon radium alone to control the disease, or contrawise feel obliged to recommend surgical follow-up.

I. General Factors

1. Of the whole series of 140 cases (1924-1942) 124 were married, 16 were single, i. e., 88% had been potentially in a position to become pregnant.

2. The following chart shows the state of gravidity, number of children or pregnancies from none to ten, with underlying line showing number of cases in each group.

0	1	2	3	4	5	6	7	8	9	10
43	25	26	12	11	1	5	3	5	3	3

In this series therefore, as 88% were married women and as slightly over 33% had never been pregnant, and 67% had two or less pregnancies, it can be said that Cancer of the Endometrium is in the greater part the disease of the childless or relatively infertile woman. It is noted however, that 19 patients — 13% had more than five children or pregnancies each.

3. The age incidence is shown for Cancer of the Endometrium and is compared in an opposite column with the age incidence found in a group of consecutive cases of Cancer of the Cervix from 1921-1942 inclusive. A third column gives relative proportion by age groups.

CANCER Age group	ENDOMETRIUM 1924-1942 140	CERVIX 1921-1942 770	PRO- PORTION 1:6
Under 31	0	26	—
31-35	0	51	—
36-40	3	97	1:33
41-45	4	98	1:24
46-50	15	118	1:8
51-55	24	115	1:5
56-60	22	114	1:5+
61-65	29	55	1:2—
66-70	26	47	1:1.8
71-75	14	32	1:2.3
76-80	2	14	1:7
Over 80	1	5	1:5

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It will be noted that while the sharp rise in incidence of Cancer of the Cervix comes between the years of 36-40, the corresponding rise in the incidence of Cancer of the Endometrium does not come until between the years of 51-55, i. e., about fifteen years later. On the other hand the incidence of Cancer of the Cervix dropped after the 60th year more than one half, while the corresponding drop in Cancer of the Endometrium did not occur until after the 70th year, i. e., 10 years later. It will be noted that while the average incidence of Cancer of the Endometrium to Cancer of the Cervix for the two groups as a whole was in the proportion of 1:6, that the relative frequency in the early age groups, up to 50 years was much lower, the proportion during the 6th decade about average, (1:5), and during the 7th decade and a half of the 8th (61-75) about 1:2.

4. Symptomatology. Bleeding from the vagina was by far the most frequent first noticed symptom. This bleeding occurred anywhere from two (2) days to fifteen (15) years before first examination. The greatest number gave the duration of symptoms as one year (21) the next as six months (19), the next as three months (10), the next as one month (6). Only three patients complained primarily of watery discharge.

5. Associated Pathology. The following pathological conditions were found associated with the Endometrial Carcinoma in the series: (1) Leiomyoma 25; (2) Polyps-non cancerous 3; Polyps cancerous 4; Polyps fibroid 1; Papillary cystadenoma of the ovary 1; Parametrial carcinomatous cyst 1; Endometriosis of the uterine wall 4; Parovarian cyst with torsion of pedicle 1; Dermoid cyst of ovary 1; Procidentia of the uterus 1; Papilloma of urethra 1; Bicornuate uterus with carcinoma in one horn 1; Primary carcinoma of lung with metastasis to spine 1; Carcinoma of breast 2; Adenoma of thyroid 1.

The incidence of leiomyomata in this series—18% seems quite low as compared with the incidence of fibroid tumors reported by other clinics. Healy reports 38% at the Memorial Hospital in New York, Masson reports 36% at the Mayo Clinic and George V. Smith 30.6%. Daniel G. Morton, however, reports 18.1% in a series of 104 cases reported in 1939. This difference may perhaps be explained by a lower incidence of surgical removal in our series. It is possible that small fibroids might escape detection where hysterectomy was not done.

II. Classification

Classification of cases into Clinical Stages, according to degree of advancement of the growth. Some system of classification as to size of growth at first examination or treatment seems necessary and convenient in attempting to estimate the effi-

cacy of treatment. While admitting the difficulties of accurately determining the extent of growth by available means such as bimanual examinations, uterine sounding etc., we still believe that we can accept certain criteria as indicating the limits of spread of the disease, and so group our cases into Stages with not too great a margin of error. We have therefore used the criteria for grouping as outlined by Healy and used by Ward and others; Stage or Group I, the uterus is of normal size, canal 3 inches deep, freely moveable and no evidence of local or distant metastasis; Stage II, the uterus the size of a 2½ months pregnancy, canal 4-4½ inches deep, still no fixation and no obvious metastasis; Stage III, the uterus the size of a 3½ months pregnancy with some break through into parametrium or adhesion to intestine or omentum, but still mobile, still technically operable; Stage IV, the large fixed uterus, inoperable, with frozen pelvis or metastasis to local lymphatic drainage area or to vaginal walls.

In this series of 80 cases to be reported on the basis of 5 year survivals, there were 19 Stage I, 23.5%; 34 Stage II, 42½%; 15 Stage III, 18.5%; and 12 Stage IV, 15% cases. Thus about two thirds of the cases were judged to be early or favorable for operation, a much better outlook than that found in Cancer of the Cervix where the early or favorable group amounts to less than one third. Therefore, Cancer of the Endometrium should be a very favorable type of Cancer to treat.

III. Pathological Grading

Another factor which is considered of prognostic significance by some well recognized authorities in Cancer of the Endometrium is the so-called Pathological Grade. Here the grouping or grading is done according to the microscopic appearance and arrangement of the cancer cells, the more adult or highly differentiated cell tumors comprising the lower grades, and the less differentiated and highly anaplastic types the higher grades of malignancy. Dr. B. Earl Clarke, our Pathologist distinguishes three grades: Grade I includes those tumors whose cells are of (1) the highly differentiated type of papillary adenocarcinoma, or (2), of the type described and called adenoma malignum by Ewing. Grade II includes a less differentiated group with gland formation still evident but with some solid blocks of cells with many mitotic figures. Grade III carcinoma is characterized by cells which are totally anaplastic, sheets of cells with no tendency to gland formation. We have 67 tumors graded in this way by Dr. Clarke for study.

IV. Results—Five Year Survival Rates

As influenced by Stage, Grade and Treatment

The five year survival rate for the whole group is 29 out of 80 or 36%. As this is the uncorrected

figure with no deductions and including all cases seen, whether treated or untreated because too advanced, or treated primarily elsewhere and referred to us later for treatment of recurrence or metastases, we speak of it as the absolute rate in distinction from the relative rate which includes only cases treated primarily by us. The following chart shows the survivals by clinical stages.

80 Cases	1924-1938	29	5 Year Survivals	36%
Stage I	19 cases	12	5 Year Survivals	63%
Stage II	34 cases	13	5 Year Survivals	38%
Stage III	15 cases	4	5 Year Survivals	26%
Stage IV	12 cases	0	5 Year Survivals	0%

The direct relation between Clinical Stage and Survival rate is here evident.

In comparison with results in treatment of Cancer of the Endometrium at other clinics in this country, our absolute figure of 36%, with 47% salvage in favorable cases is not particularly good. For instance, George V. Smith reports for the Brookline Free Hospital that of 307 cases treated by surgery alone before 1931, a salvage of 55%. Ward and Sackett report a series of 142 cases with absolute 5 year salvage of 44.4%. Heyman of Radium-hemmet in Stockholm reports of 416 patients absolute salvage of 35%. Morton in a review of the literature in 1936 found 5 year salvage figures ranging from 29.4% to 60%. Fricke reports 39% salvage of 109 cases treated by Radium alone at the Mayo Clinic.

A study of the treatment employed in our cases points to the cause of our difficulty. We find that of 19 Stage I, early favorable cases, 14 had Radium only, and that although 9 survived 5 years or more, i. e., 64%, that 4 required further treatment, 2 for local metastasis after 6 and 7 years, and that 2 required hysterectomy for recurrence in the uterus 9 and 11 years after their primary treatment. Four (4) cases had Radium followed by hysterectomy, of whom 3 survived 5 years or more. One had panhysterectomy alone and died 24 hours after operation of cerebral accident. Although the 5 year salvage (Radium alone) in this early group seems reasonably good, recurrences subsequently tend to spoil the record. And in view of the excellent results in early cases in other clinics where surgical removal played the leading role, 73.1% salvage in operable cases surgically treated by Masson and Gregg, 61.9% by Ward and Sackett, and 70.5% by Norman Miller, we must greatly question the advisability of not removing the uterus after Radium treatment in these cases. In our Stage II cases, the disadvantage of using Radium and X-ray alone becomes more pronounced. Of 9 cases receiving Radiation alone, only one survived 5 years. On the other hand, of 8 having hysterectomy alone, 5 survived 5 years. And of 10 cases receiving Radium plus hysterectomy, 6 survived, 60%. In a small group where supracervical hysterectomy followed by Radium

was used, only 1 out of 7 survived 5 years, and she died of cancer in her 6th year. In Stage III, of 15 cases, 7 had Radium and or X-ray only. All died before the 5 year interval. One who had hysterectomy alone died after 4 years. Of 6 cases having Radium followed by panhysterectomy, 3 lived five years or more, 50%. One patient who had panhysterectomy elsewhere and was treated post-operatively with Radium and X-ray at our Clinic, died of cancer in her 6th year. At no time was she thought to be free of cancer. In Stage IV, of 12 cases there was no survival. All received some sort of palliative treatment. If we summarize our results according to the type of treatment given, we find that of the 80 cases,

43 patients were treated surgically with 19 survivors 44%
37 patients were treated with Radium or X-ray only 10 survivors 27%

Of the 43 patients treated surgically,

12 patients had surgery (panhysterectomy only) 5 survivors 41%
9 patients had supracervical hysterectomy and Radium 2 survivors 22%

22 patients were treated with Radium and panhysterectomy 12 survivors 55%

that there were 30 cases Stage I, II and III, i. e., those technically operable, we find that 30 cases were treated by surgery, panhysterectomy or by Radium plus panhysterectomy, and of these 30 operable cases, 17 survived, 53%. We also find that there were 30 cases Stage I, II and III, i. e., technically operable, supposedly comparable to the above group, which were treated by Radium alone. Of these 30 cases, 10 survived 5 years, 33%. Here are figures, which, small in number perhaps, show quite clearly the advantage of using surgery as the key or principal part of the treatment, although the results with radium plus panhysterectomy are distinctly better than with surgery alone.

If surgery, panhysterectomy, is to become the important part of the treatment, there are certain essential surgical principles to be fulfilled. Obviously complete hysterectomy is required. To leave a potentially invaded cervix will be disastrous to good results, for while Radium may be used, or deep X-ray, later, the results in our series have been very discouraging. While it is probably not necessary to do the radical Wertheim operation, one should be careful to keep away from the uterine body and cervix, and not to break through the capsule of the uterus, as cancer cells often invade the myometrium deeply, even in the small uterus. Secondly, the high incidence of fibroids found when Cancer of the Endometrium is present, up to 38% in some series, makes it advisable to do the complete operation in all cases of fibroids occurring in the age group of 45 or over. Thirdly, as carcinoma cells invade deeply, and are not infrequently found in the oviducts, or may be squeezed out during operation,

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HEMOLYTIC DISEASE OF THE NEW BORN (*Erythroblastosis Foetalis*) IN ONE OF TWINS*

MAURICE ADELMAN, M.D.

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IT is now fairly well established that erythroblastosis foetalis, or as Kariher has suggested, hemolytic disease of the new born, is caused by iso-immunization of the mother by a dominant hereditary blood factor in the fetus, usually the Rh factor. It has long been recognized that icterus gravis, fetal hydrops, hemolytic anemia of the new born etc. were either variations in degree of the same underlying condition, or were very closely related, and it is therefore, more nearly correct to use the new designation. "Erythroblastosis foetalis" was first used because of the work of Levine and Stetson in 1937 in studying the serological properties of the blood of a group O mother who was delivered of a macerated fetus, and the work of Landsteiner and Wiener in 1940 who noted that rabbits injected with red cells of the rhesus monkey developed an anti-body (called the Rh factor) which could be used in testing human blood. By means of this new immune serum all human bloods could be divided into two groups. It is now known that 85% of all human blood of the white race contains this factor and this type of blood is designated Rh +. The remaining 15% does not contain this factor and is called Rh -. This Rh factor is present in the red cells only, and differs from the A and B factors which are present not only in the red cells but also in the tissue cells, blood serum and other body fluids. The anti Rh agglutinin is an acquired anti-body as opposed to the anti A and anti B agglutinins which are always and normally present in the organism.

Following this discovery, the theory of iso-immunization as cause of habitual miscarriages, hemolytic disease of the new born, intra group transfusion reactions etc. was brought forward by Levine and other workers. Hemolytic disease of the new born serves as the first known example of selective fetal or neo-natal morbidity due to a genetic and constitutional difference in a normal blood property. In spite of the widespread inter-

est in these conditions, and the number of articles that have appeared in the literature, so far as I know, less than 6 cases occurring in twins have been studied, and Kariher's case and those of Buhler, Seely and McCormick, Javert, Snyder and Ford are the only ones published. It is estimated that non-identical twins with hemolytic disease of the new born would occur about 1—18,000 deliveries. Wiener and Landsteiner first suggested that the mating of an heterozygous Rh + male with an RH - female would produce 50% normal offspring and 50% affected siblings. The following case bears this out and will add another small bit of evidence to the rapidly mounting total of statistics both as to the causation of this condition as well as to its hereditary transmission.

Case History

Mrs. H. G. C. age 35. She has 1 brother and 2 sisters alive and well. They all have 1 or more children and have no history of abnormal premature births, miscarriages etc. Two years before the birth of the present set of twins she was delivered by Caesarean section of a normal male infant. She has never been transfused and has had no miscarriages. On December 16, 1936 she was again delivered by Caesarean section. This time she gave birth to a set of twins; one male and one female. It was noted at the time of operation that there were two placentae which appeared to be normal and that the infants looked equally well, although the male weighed 7 pounds and 4 ounces, while the female weighed 6 pounds and 9 ounces. The mother and the male infant did well and they were both discharged in good condition on the twelfth day post-partum.

The female infant was noted to be drowsy and slightly jaundiced on the second day. The jaundice rapidly took on a greenish tint, and when the infant was examined at 48 hours of age it was found that the liver and spleen were moderately enlarged, and that drowsiness was quite deep. It was very difficult to get the baby to swallow. Blood examination at this time showed Hgbn. 53%-sahli, red cells 1,350,000 and white cells 19,800. There was noted a severe macrocytic anemia and 200 nucleated red cells were counted for every 100 white cells. The blood picture remained essentially the same during

*Presented at the 133rd Annual Meeting of the Rhode Island Medical Society, at Providence, May 25, 1944.

the next week, in spite of the fact that the baby received 550 c.c. of citrated blood intravenously in doses of 50-75 c.c. once or twice daily. X-ray examination of all of the long bones on the third day of life showed "none of the characteristics of erythroblastic anemia at this time". By giving daily transfusions it was just barely possible to keep the baby's blood at about the level found at the first examination. Clinically, however, the child's condition seemed to be growing steadily worse. On the thirteenth day the spleen was removed in an attempt to halt the hemolysis. This was accomplished without difficulty by Dr. R. W. and the convalescence was uninterrupted, and no further transfusions were given. The jaundice began to decrease in intensity and the patient was discharged on the 34th day of life in excellent condition. Since that time she has developed and progressed normally and is now about the same size as her brother. The excised spleen weighed 30 gms. and was $6\frac{1}{2}$ by $3\frac{1}{2}$ by 2 cms. The microscopic diagnosis was "myeloid hyperplasia and increased hemocytolysis or erythroblastic anemia".

Review of Case

In reviewing this case it is obvious that the transfusions were doing no good. The father was used as a donor twice. Due to the number of years since this case was studied, it has been impossible to trace the other donors and determine their Rh reactions but it would be safe to venture that certainly not more than one of them was an Rh — type. In spite of this the baby did not have any transfusion reactions, although the hemolysis continued unabated and at about the same rate during the entire ten days of pre-operative treatment. The probable explanation of the recovery is that the anti Rh substance in the baby's blood had been exhausted at about the time of the splenectomy and recovery might have followed without the operation and with no more transfusions.

The data on the family's bloods are as follows:-

Father — Mr. H. G. C.	O	+
Mother — Mrs. H. G. C.	AB	—
First son	B	+
Twin son	A	—
Twin daughter	A	+

Father's blood has been tested at Boston Blood Grouping laboratory and has been shown to be heterozygous.

It is of interest to report that although $7\frac{1}{2}$ years have now elapsed, the mother's blood still contains an appreciable amount of the anti Rh substance.

It has recently been possible to check the reactions of 2 of the mother's brothers—one brother (maternal uncle of patient) is type B Rh — and the other is type B Rh +.

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the greatest care should be taken to clamp or tie off the tubes at their fimbriated ends and also close to the uterine horns. A long curved clamp applied just outside the lateral uterine border accomplishes the latter purpose and serves as a tractor as well. Fourth, greatest gentleness in handling the uterus, to avoid squeezing and so forcing cancer cells out into the lymphatics of the broad ligaments is necessary. Fifth, if for any reason supracervical hysterectomy in any uterine enlargement is contemplated, a careful curettage should certainly be performed in any woman over 45 years of age, to rule out carcinoma. If carcinoma is found, and the patient's condition or the operator's skill limits the possibility of panhysterectomy, Radium and X-ray should be used in full dosage, rather than incomplete surgery. The condition may thus be rendered operable at a later date, while the patient's health may be improved to stand surgery. Too often patients are referred to our clinic after supracervical hysterectomy, when Radium and X-ray, although helpful, are at a disadvantage, difficult to apply properly, and almost sure to be followed by questionable or poor results.

Having discussed results as affected by stage and treatment, let us now return to consider the effect of pathological grade on prognosis.

EFFECT OF GRADE OF MALIGNANCY ON 5 YEAR SURVIVAL RATE

67 Cases graded by B. Earl Clarke 1924-1938

Grade I		Year Survivals					
		1	2	3	4	5	
Stage I	10	9	9	8	8	7	63%
Stage II	9	9	8	7	7	5	
Stage III	3	2	2	2	2	2	
Stage IV	2	1	0	0	0	0	
	24	21	19	17	17	14	58½%
Grade II							
		1	2	3	4	5	
Stage I	7	7	7	6	6	6	57%
Stage II	14	13	10	10	6	6	
Stage III	4	4	2	2	1	1	
Stage IV	3	1	0	0	0	0	
	28	25	19	18	13	13	46%
Grade III							
		1	2	3	4	5	
Stage I	2	1	0	0	0	0	33½%
Stage II	4	3	3	2	2	2	
Stage III	6	4	1	1	1	1	
Stage IV	3	1	0	0	0	0	
	15	9	4	3	3	3	20%

The accompanying chart shows that there were 24 cases Grade I with 14 survivals, 58½%; 28 Grade II with 13 survivors, 46% and 15 Grade III with 3 survivors, 20%. These figures seem to agree fairly closely with those of Healy and Brown, who in a larger series had 95 Grade I with 60% survivors—5 years; 45 Grade II with 42% survivors and 39 Grade III and IV with 20% survivors. Fricke also in a study of cases treated with Radium alone found that the prognosis was directly in relation to the

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grade of malignancy, the better differentiated Grade I having a salvage of 79%. The Grade II of 33%, Grade III of 25% and Grade IV of 12%. Our own and the reported cases in literature therefore seem to show that in Cancer of the Endometrium, grading is of prognostic value.

In order to determine whether the better outlook for Grade I cases might be due to the predominance of more favorable stage groups, the Grade groups were divided:

In Grade I the proportion of
Stage I and II: Stage III and IV was 4:1

In Grade II the proportion of
Stage I and II: Stage III and IV was 3:1

In Grade III the proportion of
Stage I and II: Stage III and IV was 2:3

The highest proportion of favorable cases clinically in this series fall in the more differentiated types of growth, i. e., Grade I and II. The relation in the Grade III or anaplastic type is reversed, i. e., 2:3. It may well be that the better prognosis in Grades I and II is more dependent on the earlier stage found than on the grade of malignancy itself, the more differentiated and slowly growing grades being brought to treatment at an earlier stage, while the anaplastic types, more rapidly growing, attain an advanced stage before being discovered and brought to treatment.

V. Study of Post-Radiation Hysterectomy Specimens

A study of especial interest because it should show the immediate effect which Radium possesses of ridding the uterus of tumor cells and consequently should offer us an estimation of its value in treatment when used alone, was suggested by the work of Donovan and Shields Warren. In a series of 48 uteri treated for Cancer of the Endometrium, first with Radium and then by hysterectomy, they found, on examination by the usual routine laboratory methods, only 5 specimens free of cancer cells. In some specimens they thought that the normal tissues had suffered more than the cancer tissue. Sackett reports that in a series from the Woman's Hospital that one out of three showed Cancer present. Healy and Brown found only 40% cancer-free, in a series receiving the maximum dosage of Radium and X-ray. Corscaden found 8 of 21 cases Cancer-free and George V. Smith 4 of 24 cases.

The records of 48 specimens of uteri removed after preliminary radium treatment were found in our laboratory. All had been removed 6 to 8 weeks or more after Radium treatment. All had been examined and described by Dr. B. Earl Clarke and his associates. Sections had been taken in

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routine manner from areas where cancer was thought most likely to be present. Serial sections were not done. Thirteen specimens were found to be Cancer-free, 27%. When classified as to Stage:

8 of 14	Stage I or	57%	were Cancer-free.
4 of 24	Stage II or	16 $\frac{2}{3}$ %	were Cancer-free.
1 of 9	Stage III or	11%	were Cancer-free.

When classified as to Grade:

6 of 16	of Grade I or	37 $\frac{1}{2}$ %	were Cancer-free.
6 of 18	of Grade II with	2 or 33 $\frac{1}{3}$ %	were Cancer-free.
1 of 14	of Grade III or	7%	was Cancer-free.

Of the 16 Grade I specimens:

7 of Stage I	with 4 or	57%	Cancer-free.
8 of Stage II	with 2 or	25%	Cancer-free.
1 of Stage III	with 0 or	0%	Cancer-free.

Of the 18 Grade II specimens:

5 of Stage I	with 3 or	60%	Cancer-free.
9 of Stage II	with 2 or	22%	Cancer-free.
4 of Stage III	with 1 or	25%	Cancer-free.

Of the 14 Grade III specimens:

2 of Stage I	with 1 or	50%	Cancer-free.
7 of Stage II	with 0 or	0%	Cancer-free.
4 of Stage III	with 0 or	0%	Cancer-free.
1 of Stage IV	with 0 or	0%	Cancer-free.

From the above table it is fairly obvious that the best effects of Radium are found in the Stage I where all Grades show 50% or better Cancer-free. In Stage II, Grades I and II show 25% and 22% Cancer-free — Grade III no results, 0%. In this small series Grade III offered the worst prognosis, even where similar Stages were considered. Perhaps in a larger series this might have been different, as it is generally believed that the less differentiated anaplastic grade is more susceptible to radiation. On the basis of this study where only 57% of specimens were Cancer-free after radiation in the most favorable stage, and only 27% Cancer-free in all cases, it seems fair to conclude that hysterectomy should still be considered essential in dealing with Cancer of the Endometrium.

Summary and Conclusions

1. 140 cases of Cancer of the Endometrium are presented for consideration as to marital state, gravidity, age incidence, symptomatology and associated pathology.

2. Absolute 5 year survival rates are given for 80 cases treated 1924-1938.

3. Classification of these 80 cases into Stage and Grade groups is given with basis for the same.

4. The effect of Stage and Grade on prognosis is shown.

5. 48 specimens of uteri removed after radiation are discussed as to the value of Radium in rendering the uterus cancer-free.

The effect of Stage and Grade on the cancer-lethal property of Radium in these 48 specimens is shown.

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NOW IT'S THE BLUE TRIANGLE

UNDER the official designation of the "Blue Triangle" plan a new program for financing of medical and dental bills has been introduced during the past month in Massachusetts by the Bankers Association of that state. Developed on the basis of a three year study by the Consumer Credit Commission of the banking group, and sponsored with the cooperation of fourteen clearing house associations throughout the state, the plan has received the endorsement of both the Massachusetts Medical and Dental societies.

The authors of the plan claim it has been made as simple as possible. Anyone desiring to pay the doctor's bill by installments can make application for a Blue Triangle loan through any participating doctor. A participating physician or dentist is one who agrees to endorse the patient's note form with full recourse, whereby he receives his money directly from the bank, subject to a 10% reserve to be paid him when the full amount of the loan has been paid if no other obligation of the borrower is in default.

The patient files his application with the bank for a loan, which, if approved, paves the way for him to secure the needed medical or dental care from the doctor willing to endorse the Blue Triangle note form for him. Repayments on the loan

are made by the patient directly to the sponsoring bank in from six to twelve monthly payments, with a reasonable charge added for the banking service.

The sponsors of the plan point out that the Blue Triangle is "another answer to socialized medicine." "Every doctor", says the announcement, "will see quickly the merits of this bank-financing plan in helping to preserve a free, independent medical profession. Most people fail to take advantage of the pre-payment medical plans available. With the Blue Triangle plan designed for payment of medical expense not before but after it is created, doctors are in a position to arrange for the complete health needs of people in their communities." After reading that statement is it any wonder that we in Rhode Island ask just how the Massachusetts Medical Society can sponsor at its own expense its Blue Shield pre-payment insurance program for medical care as the solution of the problem, and at the next moment support a banking plan which is publicly proclaimed as a better solution since people fail to purchase pre-payment contracts.

As for answering the challenge of socialized medicine, so-called, we fail to see the point. In the first instance the sponsoring banks intend to make certain that the individual seeking the loan is a

continued on next page

good financial risk, and we question whether every citizen applying to the bank would merit a loan, any more than every patient would merit an endorsement of the loan by his physician. In addition, the patient will have to pay more for his medical care than formerly, for he must assume the carrying charges on the loan. Hence, the only direct benefit that we can see from this distance is the provision of installment payments for the patient, and the elimination of some bookkeeping for the doctor.

But what doctor wouldn't accept payments on an installment basis direct from the patient? Granted he might lose out on many claims unless he turned them over to a professional collection agency, but would he not take that risk as readily as he would that of endorsing a note for a sizable amount which he would have to return if the borrower was in default in his payments to the sponsoring bank? And what happens to the patient when the bank approves the application, but the doctor withholds his endorsement for personal reasons?

If we are in error in our conclusions we will welcome correction. We admit that our knowledge of the new plan is gleaned entirely from the releases issued in its promotion. But we do maintain that the plan is a successful banking procedure, and that it should be promoted as a loan and collection service, not as a panacea for the distribution of the costs of medical and dental care, nor as a bulwark to preserve the freedom of the medical profession. We still think that the pre-payment plan, as demonstrated so effectively by the Blue Cross, warrants support when approaching solutions to the distribution of health care costs.

EARLY MEDICAL HISTORY

While the official start of the Rhode Island Medical Society was made in 1812 when forty-nine doctors from all sections of the state, but mostly from Newport and Providence, signed the original act of incorporation, there has often been speculation as to what attempts had been made previous to that year to effect an organization. Society documents clearly record the first meeting in the Senate Chambers of the Court House in Providence, when, at ten o'clock on the morning of April 22, 1812, the founders met to organize in accordance with the act of incorporation passed by the Assembly that year.

We are privileged to reprint below, through the kindness of the Rhode Island Historical Society, a letter in their possession which gives evidence that an attempt was made at least once previous to 1812 to form a medical society. The letter, dated in 1795, was from a Dr. Benjamin Weight and addressed

to Dr. Peter Turner of East Greenwich. The letter in its entirety is as follows:

Sir.

At a meeting of a number of Physicians of the County of Washington at the house of Robert Potter Esq. of South kingstown January 5th AD 1795 It was voted that you should be invited to attend a meeting of said Physicians at the house of Dr. Azel Anesworth of Hopkinton in said County on the first monday of march next if fair weather if not the next fair monday following to consult and agree upon proper measures and rules for forming a medical society if you think such a measure to be of Public utility and the advancement of medical knowledge therefore agreeable to said vote and in behalf of said meeting with much respect I wish your attendance at s^d meeting at s^d time and place. Sir: I am with respect and sentiments of esteem your friend and well wisher

Benja^a Weight

South kingstown January 17th. AD. 1795
To Dr Peter Turner]

Little, if any, historical data is available on Dr. Benjamin Weight. In a *HISTORY OF THE MEDICAL PROFESSION in RHODE ISLAND*, prepared by a committee of Drs. Usher Parsons, Isaac Ray and George L. Collins, and published in 1877, several physicians of various degrees of eminence residing in South Kingstown are listed, among whom is a BENJAMIN WAITE. Undoubtedly this doctor is the same one who dispatched the letter reprinted above, in spite of the variance in the spelling of his name.

Dr. Peter Turner, to whom the letter is addressed, was born in 1751, and he served as surgeon of Colonel Greene's Rhode Island regiment. At the close of the War he settled in East Greenwich and was the first physician of any note in that section. He had many students, some of whom became outstanding physicians in the state. Dr. William Turner, who won an enviable reputation at Newport as a general practitioner and an operative surgeon, was his nephew.

The identity of the Dr. Azel Anesworth of Hopkinton and of Robert Potter, Esq., of South Kingstown, to whom reference is made in the letter, constitutes a matter for historical research. At the present writing none of the Society documents reveal any Dr. Anesworth, but as not more than nine of the original incorporators of the Society had their MD it is highly probable that Azel Anesworth had rightful claim to the title of doctor.

WE ARE STILL IN THE WAR

The American mania for speed expresses itself in many ways. For example, our armies in Europe have apparently their hardest battles ahead of them, and yet we find the arm-chair strategists at home naming the day for the war's end, and we have local arrangements completed for the celebration of V-day. We would like to think the battles on the Continent will be over in the immediate future. We would like to believe that the battles yet to be fought will not be the bloody ones anticipated. But we know in our hearts otherwise. And even if the Nazis collapse, we are ever mindful of the tremendous campaign being waged in the Pacific and in the China-Burma-India theaters where so many of our own colleagues are stationed. With the realization that Germany is still far from defeated, and that it will cost almost as much to fight Japan alone as it did up to now to fight both Germany and Japan, we express the sincere hope that everyone will travel at full speed in the next few weeks to oversubscribe the 6th War Loan.

THE TITLE OF DOCTOR

Since the General Assembly of Rhode Island has never provided against the assumption of the title of "doctor" by any person, whatever his business or profession may be, we have witnessed some interesting misuses of the title through the years. The extent to which the public can be misled, having placed implicit faith in the title of "Doctor", was never better illustrated than in the recent case brought to trial in Providence.

In this instance a man released from jail in a Massachusetts city on September 22 came to Providence the same day and took residence at a local rooming house. He secured employment at a local machine shop, and at the same time apparently circulated by word of mouth the information that he was a "Doctor". His success, and the public's gullibility, is best answered by the statement that when the law caught up with him nine prescriptions he had issued to patients were reported. Only the alertness of a Providence pharmacist in notifying the State Health Department when the imposter sought prescription blanks from him brought the culprit to court within ten days after his activities had started.

Never licensed in any phase of the healing art anywhere, and with no affiliations in Providence, this "Doctor" distributed his prescriptions on the basis of "experience" gained while working in the infirmary while serving a prison sentence at Leavenworth. And the amazing part of the story is that he acquired patients here who accepted him and his advice without question!

The Governor's commission appointed two years ago to study and revise the public health laws of the State may well consider the significance of the title of doctor and make adequate provisions to safeguard the public against its misuse. There are six professional groups authorized under the healing art statutes to use the title of doctor, and of the six the clarification for chiropractors is clearest for it stipulates that "No person granted a certificate under this chapter (278) shall display or use the title 'doctor' or its synonym without the designation 'chiropractor' or 'podiatrist', and shall not mislead the public as to the limited professional qualifications to treat human ailments." This same regulation should be adapted in similar manner for doctors of medicine, doctors of dentistry, osteopathic physicians, chiropractic physicians, and optometrists.

THE HORACE WELLS CELEBRATION

It is singularly fitting that the dental profession of this State join with contemporary organizations throughout the world on next December 11 to pay tribute to the memory of Horace Wells. One hundred years ago that date, as a young Hartford dentist, Wells made his great discovery of the pain-killing effects resulting from the inhalation of nitrous oxide. Since that time his memory has been enshrined throughout the world with memorial statues in Hartford and in Paris, France. This year, the centenary of his discovery, the dental profession of America is bringing more fully and clearly to the attention of the public in general the significance of Wells' contribution in the fields of dental and medical science. He was the real discoverer, the man who saw, demonstrated, and proclaimed. He furnished the spark that lighted the way to many new discoveries and inventions based upon his original genius. Rightfully then, should all tribute be shown his memory on this occasion, for his gift was not one to science alone, but to the alleviation of suffering of all peoples of the earth.

CORRECTIONS

In the listing of the membership roster of the Society in the October issue the name of Dr. Raymond G. Bugbee of Providence was inadvertently omitted from the Providence Medical Association listing.

In the listing of Pawtucket Medical Society Dr. Edward H. McCaughey should have been checked as serving with the armed forces.

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Arch. Otolaryng., 39:109-123, 1944.



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THE CASE AGAINST THE IMPACTED TOOTH

HUBERT A. MCGUIRL, D.D.S. of *Providence, Rhode Island*

WHILE there is one school which feels that the impacted tooth should be "left alone" in as much as there is an absence of either subjective or objective symptoms or both, it is generally conceded that the conditions should be corrected.

Whenever radiographic examination discloses that the position of the tooth is one which can be corrected by orthodontia, surgery should not be done. This applies to all permanent teeth with the exception of third molars.

Often surgery and orthodontia in combination can achieve the successful eruption of a tooth in cases where orthodontia alone is unsuccessful.

This latter technique is especially effective in the latent eruption of anterior teeth, which sometimes is seen in children and even adults. The technique is relatively simple and consists in exposing as much of the crown of the tooth as possible and removing any bone impediment to its eruption. The patient is instructed in inhibitory the regrowth of soft tissues over the tooth by the daily use of a sterile orange wood stick. If the tooth does not erupt of its own accord, the orthodontia treatment is instituted to hasten the procedure and to bring the tooth to its proper place in the arch.

While any of the permanent dentition may be impacted, the teeth most often affected are the third molars and cuspids. Fourth molars, when they occur, are more often impacted than not. The predisposing cause is generally the under development of the dental arch which is in turn due to several factors including adenoids and soft diet. The cuspids and third molars being among the last of the dentition to come into place are therefore the teeth most often cheated of their place in the arch.

Sometimes an impacted tooth may remain in possession for years and may never give rise to

suggestive symptoms. On the other hand, they may give rise to symptoms which may be quite confusing. Pain, definite or indefinite, in various parts of the head, dizziness, sore throat, and swollen glands are among the chief suggestive symptoms. Often pain seems to originate in areas not immediately surrounding the impaction area.

The case of the third molar is often associated with local swelling, trismus, and diffuse cellulitis of the face. Pericoronal infection in this area is the most usual symptom which brings the patient to seek treatment.

The removal of an impacted tooth is most advisedly done while the tooth is quiescent and there is no evidence of any acute inflammation in the area.

continued on page 591

WELLS DINNER ON DECEMBER 11

The Society's Horace Wells Centenary Committee consisting of Drs. Edward C. Morin, James F. Colgan, and Walter F. Tompkins, has announced that a dinner to honor the memory of Dr. Horace Wells will be held under the auspices of the State Dental Society at the Narragansett Hotel on Monday, December 11, at 7 P. M. A reception starting at 6:30 P. M. will precede the dinner. Dr. Ambrose H. Lynch of Providence will deliver the address on the contribution of Dr. Wells to dental and medical science, and Dr. Harry M. Seldin of New York City will present a scientific paper on anesthesia. Dr. Frank P. Duffy of West Warwick will be toastmaster.

Every member of the Society should attend this Centenary Celebration dinner. Dinner tickets, at \$3.50 each, are obtainable from the following representatives of the Society:

Dr. Charles F. McKivergan	Providence
Dr. W. A. Morinville	Pawtucket
Dr. Maurice A. Denby	Warren
Dr. Paul E. Cote	Woonsocket
Dr. Arthur Dring	Newport
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CASE AGAINST THE IMPACTED TOOTH*continued from page 589*

Some of the foremost workers insist upon waiting for all acuteness to subside; but others equally capable feel that provided a wise choice of anaesthetic is used, it is permissible to remove the offender in the acute condition.

The impacted tooth is an abnormality which can cause a multiplicity of systemic disturbances as well because it is generally found to be cystic and as such, must be considered as a potential primary focus of infection.

From a medical standpoint it should not only be condemned because of its ability to ruin an otherwise normal occlusion; but also because by its intermittent activity causing pressure it can damage nervous tissue and give rise to symptoms that often defy analysis.

In summing up: Every effort should be made through adenoid removal, corrected diet, chewing exercises, and orthodontia to bring about proper expansion and development of the dental arch and thus cut down the alarming increase of impacted teeth.

In the search for focus of infection and for pain in the head, a full dental radiographic examination should be retained.

Except in the case of extraordinary contra indications, the impacted tooth should be considered a menace. At least the patient should be advised of potentialities. It should be explained that the onset of symptoms is often severe and unpleasant.

Age is not a factor. One patient I saw several years ago had an onset of violent head pains at 70 years of age. He had been wearing full upper and lower dentures for 30 years. There was a suspicion of brain tumor and a radiographic examination showed a deeply impacted cuspid, and its removal eliminated all pain.

The earlier the tooth is removed, the better, however, not only because of the advantage of earlier elimination of its potentialities but also because of the fact that the younger patient is better able to withstand the shock of surgical intervention.

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HOSPITAL CARE POLICIES OUTLINED

by American Hospital Association

THE Third War Conference of the American Hospital Association was held in Cleveland, Ohio, October 2-6, 1944.

The Association has long been concerned in having a definite statement of policy in regard to hospital care in the future. From time to time many individuals, including government agencies, have asked the officers what the position of the American Hospital Association is in regard to certain proposed policies.

The House of Delegates, therefore, adopted at this session the following official credo or statement of policy whereby the officers of the Association could determine if proposals submitted to them were in keeping with the ideals of the American Hospital Association.

"The American Hospital Association must continue to promote the best possible hospital care for the American people and to assist in making such care available to all.

"Therefore, the American Hospital Association presents the following statement of policy regarding hospital care:

- I. Ideals of the American Hospital System.
 - a. To render the best possible hospital care.
 - b. To make hospital care readily available in all areas and to all people.
 - c. To improve constantly standards of hospital care.
- II. The Hospital's Responsibility as a Community Health Center
 - a. Care of the sick — provision of the latest diagnostic and therapeutic services.
 - b. Education — Physicians, nurses, personnel and public.
 - c. Research — Medical care and hospital management.
 - d. Participation in a program of preventive medicine.
- III. Present program of the American Hospital Association.
 - a. Preservation of the values of the voluntary hospital system.

- b. Local, county, State, and Federal government aid for the care of the indigent with emphasis on local participation.
- c. Government aid for public and voluntary hospital construction upon evidence of unmet needs.
- d. Extension of inter-hospital coordination and cooperation upon urban and rural.

The American Hospital Association realizes that the existing hospital system does not fulfill completely and perfectly the hospital needs of the American people. It urges that every hospital be alert to the needs of its community. It further recommends a careful analysis of existing deficiencies and urges action to meet them progressively.

The American Hospital Association urges that as a program is developed for the realization of universal availability of hospital care the following factors be borne in mind:

1. That it be based upon evidence of unmet needs which the changes will fulfill.
2. That it be convenient and economical, utilizing to the greatest possible degree existing resources, motives and organizations.
3. That consideration be given to all other factors which affect individual and public health.
4. That the program of evolution attack the most pressing problems.

The American Hospital Association warns against decisions based primarily upon administrative expediency and therefore believes that as in other forms of human endeavor continued improvements can and will be made in hospital service for the American people. In all these matters so vitally affecting the well-being of the population, great caution should be taken at the same time to preserve American tradition and the spirit of individual initiative and enterprise.

As submitted by the Special Committee of the House of Delegates:

STUART HUMMEL, *Chairman*
 R. C. BUERKI, M.D.
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 JOHN F. MCCORMACK

CASH SICKNESS FUND ILLNESS CLAIMS

(Preliminary analysis of types of illnesses for which claims were filed against Cash Sickness Fund from April 1, 1943 to March 31, 1944)

HUGH J. HALL, M.D.

Medical Director, R. I. Cash Sickness Compensation Fund

THE statistical tables presented below give a preliminary analysis of the types of diseases and illnesses for which persons filed claims against the Rhode Island Cash Sickness Fund during the benefit year starting April 1, 1943 and ending March 31, 1944. I wish to point out, however, that these are estimates that are subject to revision. In the

final analysis, which will be completed in the near future, we believe the various totals will be increased from five to nine per cent. Also in the process of compilation at this time are statistics indicating the duration of the various types of illness and when this data is available I hope that it may be publicized in the MEDICAL JOURNAL.

TABLE 1. — *Distribution of Claimants for Cash Sickness Benefits by Medical Diagnosis, Marital Status and Sex*
FIRST BENEFIT YEAR — April 1, 1943 - March 31, 1944

	Grand Total	Male			Female		
		Total	Married	Single	Total	Married	Single
Grand Totals	33581	14987	12099	2888	18594	14124	4470
INFECTIOUS AND PARASITIC DISEASES	746	469	335	134	277	145	132
typhoid fever and dysentery	7	4	4	***	3	2	1
Childhood diseases, measles, mumps, etc.	76	34	27	7	42	20	22
tuberculosis — various forms of	397	273	183	90	124	68	56
Gonococcus infection — various forms	3	3	1	2	.....	.....	.....
malaria — various forms of .....	.....	.....	.....	.....	.....	.....	.....
syphilis — various forms of	23	17	13	4	6	3	3
other infectious and parasitic diseases	240	138	107	31	102	52	50
NEOPLASMS (Tumors, Cysts, etc.)	549	285	228	57	264	190	74
malignant neoplasms, types of	241	164	132	32	77	58	19
non-malignant neoplasms, types of	308	121	96	25	187	132	55
RHEUMATIC FEVER, DISEASES OF THE ENDOCRINE GLANDS AND NUTRITION AND OTHER GENERAL DISEASES	680	208	163	45	472	326	146
Acute rheumatic fever, forms of	126	54	43	11	72	42	30
endocrine glands — various diseases of	479	129	101	28	350	251	99
Nutritional and other general diseases	75	25	19	6	50	33	17
DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS	499	74	60	14	425	303	122
anemia — various forms of	489	69	58	11	420	298	122
other blood and blood organ diseases	10	5	2	3	5	5	.....
CHRONIC POISONING AND INTOXICATION	6	5	4	1	1	.....	1
alcoholism, lead, drug, other chronic	6	5	4	1	1	.....	1
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS, INCLUDING MENTAL DISORDERS	2498	944	760	184	1154	1116	438
neural diseases — various forms of	757	446	372	74	311	238	73
mental disorders — various forms of	1357	300	226	74	1057	770	287
organs of vision — various diseases of	287	163	134	29	124	69	55
ear and mastoid process — diseases of	97	35	28	7	62	39	23

CASH SICKNESS FUND ILLNESS CLAIMS

595

	Grand Total	Male			Female		
		Total	Married	Single	Total	Married	Single
DISEASES OF THE CIRCULATORY SYSTEM	3288	1754	1463	291	1534	1201	333
heart disease — various forms of	1510	947	795	152	563	422	141
arteries — various diseases of	884	414	336	78	470	382	88
veins — various diseases of	657	317	272	45	340	277	63
other circulatory system diseases	237	76	60	16	161	120	41
DISEASES OF THE RESPIRATORY SYSTEM	5170	2673	2210	463	2497	1519	978
influenza	1588	802	674	128	786	472	314
common cold	121	50	33	17	71	41	30
tonsillitis with tonsillectomy	49	19	12	7	30	16	14
larynx & pharynx — various diseases of	519	213	176	37	306	159	147
bronchitis — various diseases of	1095	545	455	90	550	347	203
pneumonia — various forms of	1030	650	541	109	380	226	154
other respiratory system diseases	768	394	319	75	374	258	116
DISEASES OF THE DIGESTIVE SYSTEM	4100	2374	1918	456	1726	1023	703
mouth & esophagus — diseases of	83	27	23	4	56	25	31
ulcers of stomach & intestines	658	525	439	86	133	102	31
diarrhea and enteritis	238	93	76	17	145	98	47
appendicitis — various forms of	880	319	240	79	561	197	364
hernia — various forms of	966	900	723	177	66	51	15
nervous indigestion	121	29	22	7	92	64	28
other stomach and intestinal diseases	501	277	223	54	224	134	90
liver & gall bladder — diseases of	629	199	169	30	430	345	85
other digestive system diseases	24	5	3	2	19	7	12
Grand Totals	2554	419	333	86	2135	1804	331
DISEASES OF THE GENITO-URINARY SYSTEM	489	213	172	41	276	218	58
kidneys & ureters — diseases of	61	29	23	6	32	26	6
other urinary system diseases	177	177	138	39	1827	1560	267
male genital organs — diseases of	1827						
female genital organs and breast							
DELIVERIES AND COMPLICATIONS OF PREGNANCY, CHILDBIRTH, THE PUERPERIUM	4333				4333	4257	76
pregnancy — and complications of	4333				4333	4257	76
DISEASES OF THE SKIN	659	387	293	94	272	159	113
skin diseases — eczema, impetigo, etc.	659	387	293	94	272	159	113
DISEASES OF THE BONES AND ORGANS OF MOVEMENT	1997	1044	846	198	953	712	241
arthritis — various forms of	1364	678	570	108	686	550	136
other bone, joint & muscular diseases	633	366	276	90	267	162	105
CONGENITAL MALFORMATIONS	12	10	2	8	2	1	1
congenital malformations, types of	12	10	2	8	2	1	1
DISEASES PECULIAR TO THE FIRST YEAR OF LIFE	2	1	1		1	1	
injury at birth, prematurity, etc.	2	1	1		1	1	
OTHER AND ILL-DEFINED DISEASES	951	382	286	96	569	360	209
lumbago, neuralgia, nervousness, etc.	688	259	209	50	429	286	143
all other diseases	263	123	77	46	140	74	66
ACUTE POISONINGS AND INJURIES	5535	3956	3195	761	1597	1007	572
acute poisoning — food acid, drug, etc.	21	15	12	3	6	4	2
injury by foreign body, concussion, etc.	139	106	83	23	33	21	12
compound fracture injuries	1130	861	697	164	269	176	93
simple fracture injuries	568	441	343	98	127	66	61
dislocation, sprain, etc. no fracture	1466	966	789	177	500	367	133
burn or scald injuries	188	131	102	29	57	30	27
cut laceration, or puncture injuries	463	346	257	89	117	66	51
superficial injuries — abrasions, etc.	452	309	256	53	143	87	56
other or unspecified injuries	1108	781	656	125	327	190	137
OTHER CONDITIONS	2	2	2				
Diagnosis not recorded							
Marital status not recorded							

continued on page 597



Proud...of course she is

Her baby is a happy, contented 'Dexin' baby, untroubled by the seasonal intestinal upsets all too commonly associated with excessive carbohydrate fermentation.

When 'Dexin', a high dextrin carbohydrate, is used as the milk modifier, infants are notably free from intestinal fermentative reactions. 'Dexin' reduces the possibility of distention, colic and diarrhea.

'Dexin' formulas are easily digested. The high dextrin content favors soft milk-curd formation. 'Dexin' is readily soluble in hot or cold milk.

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'Dexin' does make a difference

COMPOSITION

Dextrins . . .	75%	Mineral Ash . .	0.25%
Maltose . . .	24%	Moisture . . .	0.75%

Available carbohydrate 99% 115 calories per ounce
6 level packed tablespoonfuls equal 1 ounce

Dexin
HIGH DEXTRIN CARBOHYDRATE



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TABLE 2. — *Distribution of Male Claimants by Age Groups and Types of Sickness*

FIRST BENEFIT YEAR — April 1, 1943 - March 31, 1944

General Classification of Sickness	Total	Under 16 yrs.	16-20	21-25	26-30	31-35	36-40	41-50	51-60	61 yrs. and over
Total No. of Claimants	14987	1	537	556	1129	1275	1422	3207	3334	2645
Total Cases — Data available	14106									
Total Cases — Data not available	881									
INFECTIOUS AND PARASITIC DISEASES	441		41	30	58	61	48	93	69	41
age data not available	28									
NEOPLASMS	273		6	14	13	4	24	52	71	89
age data not available	12									
RHEUMATIC FEVER, DISEASES OF the endocrine glands	198		7	13	16	12	23	37	49	41
nutrition and other general diseases										
age data not available	10									
DISEASES OF THE BLOOD AND BLOOD FORMING ORGANS	68			4	2	3	2	14	18	25
age data not available	6									
DISEASES OF THE NERVOUS SYS- TEM AND SENSE ORGANS, IN- CLUDING MENTAL DISORDER	897		15	32	53	82	67	211	250	187
age data not available	47									
DISEASES OF THE CIRCULATORY SYSTEM	1661		15	14	38	62	82	289	504	657
age data not available	93									
DISEASES OF THE RESPIRATORY SYSTEM	2504		77	79	184	195	271	622	630	446
age data not available	169									
DISEASES OF THE DIGESTIVE SYSTEM	2235		121	110	188	223	266	581	472	274
age data not available	139									
DISEASES OF THE GENITO- URINARY SYSTEM	398		12	11	20	31	35	65	119	105
age data not available	21									
DISEASES OF THE SKIN	370		22	15	34	39	47	84	75	54
age data not available	17									
DISEASES OF THE BONE AND ORGANS OF MOVEMENT	986		19	38	62	90	81	227	254	215
age data not available	58									
CONGENITAL MALFORMATIONS	8		4		1		1		2	
age data not available	2									
DISEASES PECULIAR TO THE FIRST YEAR OF LIFE	1									
age data not available										
OTHER DEFINED DISEASES	333		13	13	28	28	28	63	89	71
age data not available	49									
ACUTE POISONINGS AND INJURIES	3726	1	185	183	430	444	446	866	732	439
age data not available	230									
OTHER CONDITIONS	2				1	1				
CHRONIC POISONING AND INTOXICATION	5									
age data not available										

continued on page 599

CIBA PHARMACEUTICAL PRODUCTS, INC.
SUMMIT, N. J.
Medical Department

MEMORANDUM FROM: Medical Director
TO: Advertising Manager

In view of recent lay publicity on the value of male hormone therapy in cardiovascular conditions and the male period of involution, many men may be approaching physicians asking for treatment, and while therapy may be justified in a certain percentage of cases, you surely know, only the physician can so determine.

Naturally, it is contrary to Ciba policy to discuss such matters with the laity and we have very carefully referred all individuals seeking information to their physicians. It is quite evident however, that this publicity has aroused a great deal of interest. I would suggest that you prepare copy, re-stating our attitude of such information to the laity and offer publication of such information to the laity and offer to the profession our most recent literature describing clinical results with androgenic preparations in these conditions.

NOTE:

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clear, understandable copy*
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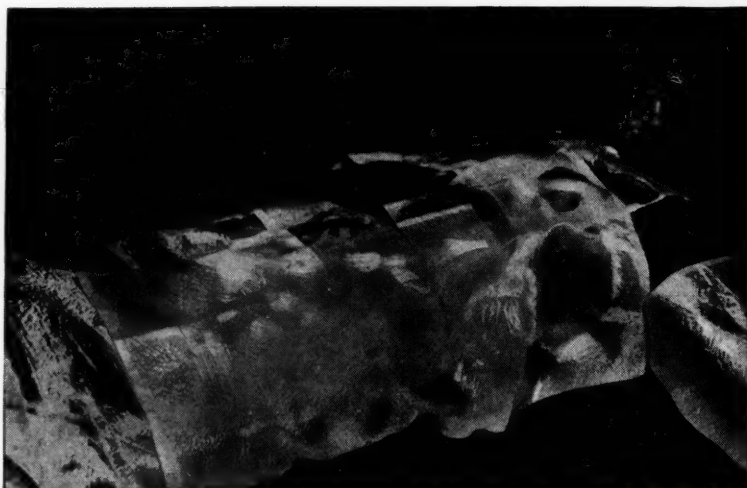
PERANDREN*

*a Ciba
Product*

TABLE 3. — *Distribution of Female Claimants by Age Groups and Types of Sickness*

FIRST BENEFIT YEAR — April 1, 1943 - March 31, 1944

General Classification of Sickness	Total	16-20	21-25	26-30	31-35	36-40	41-50	51-60	61 yrs. and over
Total No. of Claimants	18,594								
Total Cases — Data available	17,540	1493	2991	2739	2398	2225	3551	1677	466
Total Cases — Data not available	1,054								
INFECTIOUS AND PARASITIC DISEASES.....	257	46	48	44	25	31	33	26	4
age data not available	20								
NEOPLASMS	251	12	15	21	33	36	101	23	10
age data not available	13								
RHEUMATIC FEVER, DISEASES OF THE ENDOCRINE GLANDS, NUTRITION AND OTHER GENERAL DISEASES	441	35	52	54	75	71	86	56	12
age data not available	31								
DISEASES OF THE BLOOD AND BLOOD FORMING ORGANS	402	38	68	62	66	55	74	31	8
age data not available	23								
CHRONIC POISONING & INTOXICATION.....	1		1						
age data not available									
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS, INCLUDING MENTAL DISORDERS	1464	73	191	218	229	237	312	154	50
age data not available	90								
DISEASES OF THE CIRCULATORY SYSTEM	1461	35	65	103	154	178	456	325	145
age data not available	73								
DISEASES OF THE RESPIRATORY SYSTEM	2365	161	303	285	334	375	570	271	66
age data not available	132								
DISEASES OF THE DIGESTIVE SYSTEM.....	1626	271	259	202	213	224	274	154	29
age data not available	100								
DISEASES OF THE GENITO URINARY SYSTEM	2003	70	153	230	266	324	778	168	14
age data not available	132								
DELIVERIES AND COMPLICATIONS OF PREGNANCY, CHILDBIRTH, THE PUERPERIUM	4130	515	1497	1168	633	265	51	1	
age data not available	203								
DISEASES OF THE SKIN	260	41	25	32	33	36	63	29	1
age data not available	12								
DISEASES OF THE BONE AND ORGANS OF MOVEMENT	897	38	62	83	87	117	284	177	49
age data not available	56								
CONGENITAL MALFORMATIONS	2				1	1			
age data not available									
DISEASES PECULIAR TO THE FIRST YEAR OF LIFE	1						1		
age data not available									
OTHER & ILL DEFINED DISEASES	497	30	74	71	78	66	116	47	15
age data not available	72								
ACUTE POISONINGS & INJURIES	1482	128	178	166	171	209	352	215	63
age data not available	97								



Uses of Fiberglas in Medicine*

Physicians, surgeons and others engaged in medical research have, in recent years, employed various Fiberglas materials experimentally and have found them uniquely fitted for certain uses.

For example, Fiberglas cloth (ECC-11-108) was used to help measure the protein loss in the exudate from surface burns. As illustrated, the Fiberglas cloth was placed next to the burned skin of a 12-year-old Negro girl. It is the first layer of a bandage devised to collect the exudate in order accurately to measure nitrogen loss from the burned skin surface. The patient was admitted to a Detroit hospital in January, 1944. The burn, caused by hot water, involved about 12 per cent of the body surface. "The burn healed rapidly,"



says the report in *Surgery*, "and the amount of nitrogen lost in the exudate from the burned area diminished as healing progressed."

This method of determining the magnitude of the protein loss from the burned surface gives physicians a comprehensive picture of the metabolic upset for the first time and thus will permit improved replacement therapy.

Fiberglas is glass in fiber or filament form. Glass textile fibers, ranging in diameter from four ten-thousandths of an inch to less than two ten-thousandths of an inch are formed into yarns which are woven into a wide variety of textiles.

Fiberglas is an inorganic, nontoxic, nonallergenic, nonsensitizing and chemically stable substance which produces no harmful effect upon human tissue. It is pliable and possesses great tensile strength. It has high dimensional stability, resists high temperatures, steam, corrosive fumes and acids (except hydrofluoric). Fiberglas is nonhygroscopic and nonflammable. It is easily sterilized and resterilized, and in a special form is radiopaque.

It is the policy of Owens-Corning Fiberglas Corporation to supply samples of Fiberglas in any available form to qualified persons engaged in research. The new brochure describing such other pioneering uses of Fiberglas as:

- Tracer Threads in Surgical Sponges
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- Fiberglas-Plastic Artificial Limbs

... may suggest ways in which Fiberglas can help solve other problems. Ask your secretary to send for your copy today. Write Owens-Corning Fiberglas Corporation, 2036 Nicholas Bldg., Toledo 1, Ohio.



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INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH

Charles L. Farrell, M.D., *Chairman*; Stanley Davies, M.D.; Arthur E. Martin, M.D., Elihu S. Wing, M.D., William P. Buffum, M.D.

THE HANDICAPPED VETERAN IN INDUSTRY

The return of the physically handicapped veteran from military to civil life will present a problem to industry. The industrial physician will do well to consider plans to provide employment for such men. Now is the time to consult with Management, Personnel Directors and other officials in planning for the use of handicapped veterans.

Industrial physicians should suggest plant studies and surveys to determine the type of jobs that can be handled by persons with major or minor defects, such as the loss of one or both arms or legs, the loss of one eye or of hearing. The industrial physician can help materially by setting up physical standards for the employment of veterans in the specific jobs of the plant. In order to do this the physician must be thoroughly familiar with all operations within the plant—the type of procedures involved—the hazards—and the measures needed to correct such hazards.

Speaking in Boston recently, Dr. C. O. Sappington, editor of "Industrial Medicine", stressed the necessity for "plant walks" similar to ward walks in the hospital. He urged industrial physicians to get out into the plant, make a survey of existing conditions, offer suggestions for correction and be alert to hazards and their prevention. "We are an industrial nation," he stated, "why haven't we made greater advance in the field of industrial health?"

With the return of the veteran to civil life, the industrial physician will be expected to have a great deal to say regarding his placement and his welfare in industry. Now is the time to prepare! We urge industrial physicians to take up the problem with Management at the earliest possible moment and look around their plants to see wherein they can be of service in placing handicapped veterans where they will be most useful and most happy.

SMALL PLANT MEDICAL DEPARTMENTS

To those physicians who go to plants only on call, the Committee on Industrial Health of the State Medical Society offers its services in establishing a small plant Medical Department if desired.

We believe that even small plants should have an adequately equipped first-aid room and, wherever

possible, the services of a nurse even if it is the visiting nurse instead of a full-time employee. We would like to arrange for one physician to cover a series of small plants. If we can interest Management of adjacent or nearby small plants in its establishing first-aid rooms or a community first-aid room with the services of a nurse, we feel that we can materially assist in establishing a health program. Representatives of the Division of Industrial Hygiene in the State Department of Health and members of this committee would like to meet the superintendent or manager of the plant, the president of the company, or some other official, as well as the personnel man, the director of the safety committee, a representative of the employees and first-aid man if one is available. We welcome inquiries regarding this plan.

Fellowship in Industrial Medicine

A Fellowship in Industrial Medicine has been established in the University of Pittsburgh School of Medicine, Department of Industrial Hygiene, by a grant of \$2500.00 from a James S. Kemper Foundation. The purpose of the fellowship is to give post graduate work to physicians desiring to enter Industrial Medicine. For further information, apply to Dr. William S. McEllroy, Dean of the University, Pittsburgh, Pa.

Cold Vaccines Again

Now that the fall season is with us manufacturers of cold vaccines have again attempted to interview industrial Management in an effort to interest them in promoting the distribution of cold vaccine capsules among the employees. We reviewed the subject of cold vaccines last year. We would not mention it again except for the fact that one company promoting the use of cold vaccine in industry has been submitting testimonials as to its efficacy from such uninformed and unscientific sources as a chief of police, a personnel director, the vice president of a corporation, a safety director and an employee service director. We consider it an insult to our intelligence that any pharmaceutical house would ask us to consider as evidence the unscientific opinions of laymen as to the efficacy of a controversial pharmaceutical in the field of health. Medicine moves forward on the basis of scientific evidence not on the opinions of the laity.



TOWARD THE GOAL THAT
ALL WHO NEED IT MAY
HAVE IT...

PENICILLIN *Schenley*



TODAY on all our battlefronts many an Allied soldier owes his life to the fact that penicillin is now being produced in sufficient quantities to meet the most important military needs. And as military needs are more fully met, there will be increasing amounts of penicillin available for civilian use.

Contributing to this accomplishment have been the resources of 21 firms appointed by the Government to produce the precious new drug.

Schenley Laboratories, Inc., are proud to be among those chosen to attack the almost insuperable technical difficulties in the manufacture of penicillin. The devotion of our facilities to this purpose is a natural outgrowth of the extensive research in mycology Schenley Laboratories have been conducting for many years.

We are glad to be working wholeheartedly toward the goal that... in the near future... all who need penicillin may have it.

SCHENLEY LABORATORIES, INC.

EXECUTIVE OFFICES: 350 FIFTH AVENUE, N. Y. C.



MEMORIES OF 1918

As the twenty-sixth anniversary of the Armistice of World War I arrives while the nations of the world continue to fight for the finish of World War II, we paused to review the happenings of 1918 as viewed in the issues of the Rhode Island Medical Journal of that year. The similarity in the reporting of events of that day with the present day announcements is striking.

In May, 1918, the Journal editorially stated that "unless this country puts forth every ounce of its strength in all lines of endeavor we shall be forced by a German victory to pay an indemnity beside which our present income taxes and Liberty Loan subscriptions would pale into insignificance."

On April 8 Captain Fenwick G. Taggart, now vice president of the Society, and Captain Joseph Hawkins, then business manager of the Journal, were reported as leaving for service at Fort Oglethorpe. The first war casualty was reported in the untimely death of Dr. Peter L. Keough of Pawtucket. Commissioned a Lieutenant shortly after the United States entered the war, Doctor Keough soon won his captaincy. He contracted pneumonia while on duty at Camp Sherman in Ohio, and the illness proved to be fatal on April 15.

Unit Organized

In mid-May nine of the doctors assigned for duty with the Navy Base Hospital, Unit 4, left for preliminary instruction at Newport. In this first group were Lieutenants (senior grade) L. C. Kingman, W. H. Buffum, and A. A. Barrows, and Lieutenants (jg) Alex M. Burgess, Paul Cook, Elihu S. Wing, Frank H. Mathews, and Henry L. Johnson. Later others, including Lt. Comdr. Halsey Dewolf, Lt. Comdr. George Matteson, Lieutenants (s) Roland Hammond, F. V. Hussey, Joseph C. O'Connell, Lewis B. Porter, C. S. Westcott, and Lieutenants (jg) William P. Buffum, Jr. and George Eckert, of Newport, were listed to join the Unit.

Appealing for medical volunteers for the Army, Surgeon General W. C. Gorgas was quoted in the May issue of the Journal as stating "we are now entering the fighting phase of the war . . . by the end of the year a million and a half men will be in France. Fifteen thousand medical officers will be required for that Army alone. There are on duty today 15,174 officers of the Medical Reserve Corps."

Physical Defects of Inductees

At the May meeting of the Providence Medical Association in 1918, Dr. George S. Mathews, speaking on "Some Cardio-Vascular Considerations in Connection with Advisory Draft Board Examinations", summarized with conclusions strangely familiar to us in 1944. He stated that "The statistics that are accumulating in regard to registrant examinations will be illuminating. In an analysis of some 9,000 cases one writer noted that 29% were rejected on physical grounds. Eyes, teeth, weight, in the order named, were the largest contributing causes. The heart was responsible for about 2½% of rejections. It is stated by competent observers that in a population of military age between 19 and 45 about 50% would be found disqualified. This is startling and, if true, calls for radical reform in the hygienic education of the people in the overcoming of much preventable physical deficiency. In the words of Kipling:

'It ain't the individual,

Nor the army as a whole,
But the everlastin' team work
Of every bloomin' soul'."

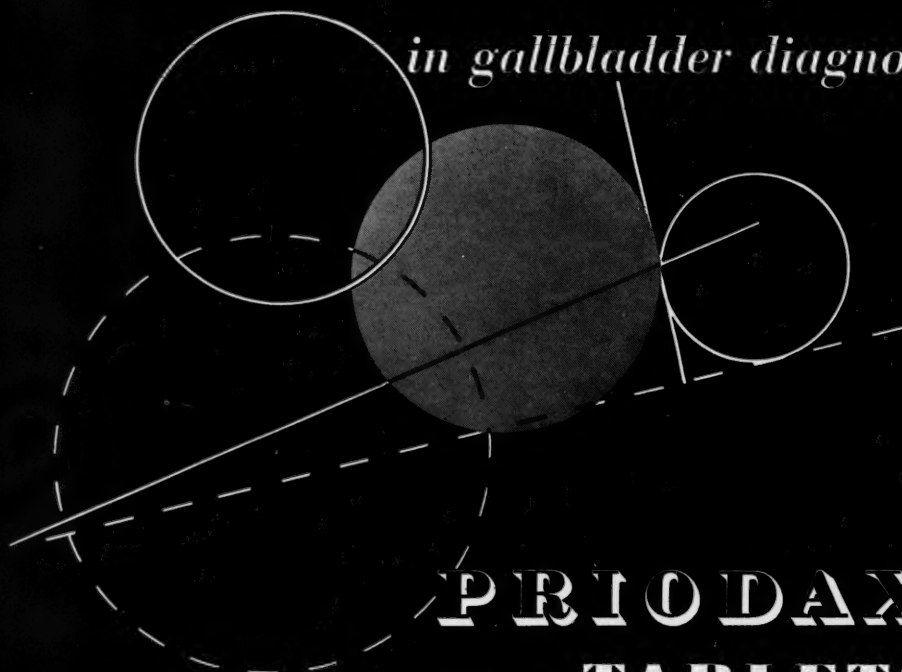
Enlistments

In his presidential address, read before the Society on June 6, Dr. John Champlin of Westerly relates that 137 of the 751 physicians in the State have enlisted for duty with the armed forces, with 118 serving with the Army and 19 with the Navy.

continued on page 607

EXACTNESS

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Safe and well tolerated
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MEMORIES OF 1918

continued from page 605

On June 3, Dr. G. A. Blumer called attention at the meeting of the Providence Medical Association to the Red Cross drive for nurses, and he asked for the assistance of the members in securing the quota for Rhode Island. On June 6, Lt. Comdr. John C. DaCosta, surgeon in the USNRF, addressed the Society on the "Medical Activities of the Navy".

Rehabilitation

In an editorial in the June issue we find the following observation regarding scientific medicine and the war which strikes a responsive chord as we now talk of rehabilitation plans for veterans: "... with the establishment of reconstruction centers, each having a physio-therapeutic plant for treatment, curative workshops and trade schools, and with the cooperation of federal employment bureaus, the man will be guided and taught until he is self-supporting. It is encouraging to feel that the cripples of the present war will not be allowed to drift and to fill our institutions with derelicts as in previous wars, but will become respectable and self-supporting citizens."

Personals

July 1918. The Society proudly records that "one of its members, Lieut. Bertram H. Buxton, serving with our forces in France, has been awarded the Medal of Honor for bravery under fire."

Captain Herman C. Pitts and Captain John B. Ferguson have been ordered to Philadelphia to receive special instruction in brain surgery.

Lieut. Anthony Corvese has arrived safely "somewhere in France" where he states there are many chateaux and gardens.

Captain Frank M. Adams has been commissioned and is awaiting orders for nose and throat work.

BEGINNINGS OF THE EMIC?

In the August issue appeared a brief review of the booklet titled "CHILD CARE". In the comment the following is noted:

"Things every mother must know if the nation is to meet the health needs of its children as indicated by the draft and still further revealed by the weighing and measuring test have been made available recently by the Children's Bureau of the U. S. Department of Labor in its new bulletin on Child Care, prepared by Mrs. Max West.

"CHILD CARE has been prepared in the hope that it would enable mothers to understand and recognize symptoms which indicate the need of special care . . ."

"CHILD CARE . . . is the third issue in the series which began with PRENATAL CARE and INFANT CARE . . ."

Play Safe

Every doctor knows the value of Homogenized Milk. And every doctor should know that A. B. MUNROE DAIRY GRADE A HOMOGENIZED MILK is a quality product because it is processed under the most stringent laboratory control.

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DISTRICT SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, October 2, 1944.

The meeting was called to order by President Albert H. Jackvony at 8:30 P. M.

The President announced that since the minutes of the last meeting had been published in the RHODE ISLAND MEDICAL JOURNAL the reading of them would be omitted unless there was objection.

The Secretary reported the receipt of a communication from Dr. Lewis T. Bennett, Medical Director of the Walsh-Kaiser Company shipyard in Providence, asking for assistance in securing local doctors interested in part time work at the shipyard.

The Secretary reported the receipt of a communication from the Public Service Publications calling attention to the numerical telephone list for 1944-45. This publication lists the telephone number for nearly the entire state in numerical sequence and attention is directed to it because of its possible interest and value to the members of the Association. The Secretary reported that a copy of the publication was available at the Executive Office for any doctor interested in viewing it.

The President reported that the Committee of Dr. Roland Hammond and William O. Rice had submitted the Association's tribute to the late Dr. Nathaniel H. Gifford, and the Committee of Dr. Herbert Partridge and Charles O. Cooke had submitted the Association's tribute to the late Dr. William Bryant Cutts.

The President introduced Mr. Covell, Division Representative of E. R. Squibb & Sons who briefly outlined the background for the new motion picture in sound on "Nutrition" produced by his company. After this explanation Mr. Covell showed the picture.

Two representatives of E. R. Squibb & Sons, Mr. Covell and Mr. Goulding presented an interesting forty-minute film on nutrition. The content included talks by several experts giving details, illustrated by pictures of patients, of the diagnosis and treatment of numerous nutritional deficiencies. The film was of definite educational value.

Dr. Joseph F. Hawkins made some remarks on the history of efforts to transplant pieces of cornea to take the place of excised opaque corneal tissue.

A film was then presented showing the operative technique of Dr. Ramon Castroviejo. Dr. Castroviejo has done more than anyone to advance the technique and improve the results obtained by this operation. Pictures of patients were included who had corneal transplantations remaining clear for as long as one to ten years. Questions were asked from the floor which Dr. Hawkins answered.

The President introduced Mr. William L. Connolly, State Director of labor under whose jurisdiction the new State Rehabilitation Center is to be operated. He explained briefly the origin and the law covering the setting up of the curative center under the direction of the Department of Labor. Dr. John Donley, who has been made Director of the Curative Center, also discussed the matter. Both gentlemen answered numerous inquiries from the members present.

The meeting adjourned at 11:00 P. M.

Attendance 55:

Respectively submitted,

FRANK W. DIMMITT, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The first fall meeting of the Pawtucket Medical Association was held in the Nurses' Auditorium of the Memorial Hospital on September 21, 1944 at 12 noon.

After a short business meeting the speaker of the day, Dr. Stanley Sprague, was introduced by the president, Dr. Edward Trainor. Dr. Sprague spoke on "Headaches from the Cash Sickness Benefit Program", and gave a very interesting talk. He presented his subject from the point of view of an examining physician of the Compensation Board and pointed out that there were just as many difficulties to be surmounted by the examining board as there were by the family physicians. After a short but spirited discussion period the meeting was adjourned.

The October meeting of the Pawtucket Medical Association was held at 12 noon, October 19, 1944, at the Memorial Hospital. The meeting was called to order by the president, Dr. Edward Trainor. It was decided to continue the weekly radio talks and Dr. Stanley Sprague, chairman of the radio committee, was requested to complete arrangements

with the local station. Dr. Charles Farrell's recent publication in the Providence Bulletin in regard to socialized medicine was discussed and the Society commended Dr. Farrell upon the excellence of his article; it was voted that the article be sponsored by the society for further publication and distribution.

The speaker of the day, Miss Mary Nunez, R.R.L., of the Memorial Hospital, was introduced by the president. Her paper entitled, "The Medical Record—Its Importance to the Hospital and the Physician", was interesting and enlightening. She stressed the fact that inaccurate and incomplete records are of little value to anyone, whereas accurate, complete records may be used to further medical science, to further the physician's knowledge, and to protect the patient and to assure him that proper medical care is being rendered. She stated that, "From the medical record, the medical staff and administration of the hospital are able to analyze the quality and quantity of the work which has been done. It enables them to study the immediate results such as deaths, improved or unim-

proved cases. If death ensues, search for the cause can be made and may result in the elimination of causes that may be preventable. If a patient is improved on discharge, what contributed to the improvement is important. If not improved it is still more necessary to find out the reason. These results should justify the expenditure. The hospital is responsible for knowing the exact results obtained and the reasons. In this manner, the hospital protects its reputation and its ability to render the best services that its staff and facilities will permit." She pointed out that the record is necessary for the protection of the hospital and the physician in case of medico-legal action, and cited several interesting court cases in which hospital records were used as evidence. In concluding, she again stressed that hospital records do serve a specific usefulness depending upon their completeness and accuracy and that the hospital and physician may find numerous uses for them.

Luncheon was served, after which the meeting was adjourned.

Mary-Elaine J. Rohr, M.D.



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collapse following accidents or surgical trauma
opiate and barbiturate depression • asphyxia
denarcotization after general anesthesia •
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gencies of pneumonia • • • • •

In the Management of Severe Third-Degree Burns

much has been learned through the unfortunate occurrence of the Coconut Grove fire at Boston. The numerous reports in the medical press emphasize the need for large amounts of dietary protein of adequate biologic value, given as early as possible.* Meat is one of man's main sources of protein that can be eaten with relish several times daily in goodly quantities; its proteins are of highest quality, and it contributes to the satisfaction of the greatly increased vitamin requirements as well.

*"All the patients with ten per cent of surface area, or more, involved in third-degree burns became serious nutritional problems. . . . All patients were started on high protein, high vitamin diets. . . . This diet contained 140 Gm. of protein." (Clowes, G. H. A., Jr.; Lund, C. C., and Levenson, S. M.: The Surface Treatment of Burns, *Ann. Surg.* 118:761 [Nov.] 1943.)

"... at least from 200 to 300 grams of protein is needed for replacement alone. One must give the patient as much food as he can take . . . give him a good protein, one that contains all of the essential amino acids." (Elman, R.: *Physiologic Problems of Burns*, *J. Missouri M. A.* 41:1 [Jan.] 1944.)



The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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Report of The Committee on UNIVERSITY, HOSPITAL, and MEDICAL SOCIETY RELATIONS

THE Committee on University, Hospital, and Medical Society Relations met with its Advisory Council on Thursday, September 21, 1944 at 8:30 P. M. in the Rhode Island Medical Library. The Advisory Council is made up of one representative from each of the regional medical societies and one from each hospital in Rhode Island. No representative was present from Washington County Medical Society or from Woonsocket Medical Society. With the single exception of Westerly Hospital every hospital was represented.

The committee submitted to the Advisory Council the following specific proposals:

- (1) That hospitals reorganize their staffs and their plans for teaching programs as suggested with especial emphasis on duties of the consulting staff.
- (2) That all hospitals plan to increase their interne and resident staffs to afford better study and treatment of their patients. Under this heading it is specifically suggested that those hospitals who have no internes plan to hire a paid house officer, preferably for a short appointment with frequent turn over. It is suggested that as internes graduate from the larger hospitals they will readily be available for such appointments.
- (3) That a Rhode Island Medical Society faculty be organized to be available to present a variety of subjects at meetings—as they may be requested by hospitals or county societies. This arrangement would leave the county societies, hospitals or other groups free to plan their own programs and to request the services of such members of the faculty as they might wish to hear. A list of the faculty and the subjects they were prepared to present would be sent to the hospitals and county societies every year and schedules would be arranged by a com-

mittee in charge with a view to meeting all requests as far as possible.

- (4) That further studies as to the possibility of a pathological institute, or some similar cooperative organization, be made in the hope that the opportunities for complete laboratory service for all hospitals be increased as far as possible.
- (5) That Brown University be specifically requested to study the possibility of offering courses of the type mentioned for the benefit of members of the Rhode Island Medical Society.

After introductory discussion of these proposals by Dr. Burgess and Dr. Clarke there was lively and interesting discussion by all present. Dr. Burgess then called for a vote on the following points:

- (1) Should the Committee go ahead on its study for a plan for internships?
- (2) Should the Committee plan for a Rhode Island Medical Society faculty to consist of anyone who has any contribution to make, with the Committee urging outstanding men and teams to enroll?
- (3) Shall the Committee initiate a further study for an Institute of Pathology?
- (4) Shall the university and colleges of the state be requested to study the possibility of offering special courses and lectures for the medical profession?

Unanimous approval was given to each of these proposals.

The committee now submits these same recommendations to the House of Delegates. If your approval is forthcoming we propose to continue our studies along these lines in the hope of arriving at specific and detailed recommendations.

B. EARL CLARKE, M.D., *Chairman pro tem*

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CARCINOMA OF THE ENDOMETRIUM

*continued from page 582***Conclusion**

As a result of this study, we conclude that Cancer of the Endometrium is essentially a disease to be treated by surgery, panhysterectomy, but that the prognosis can be greatly improved through the use of Radium or X-ray as a preliminary to the surgery.

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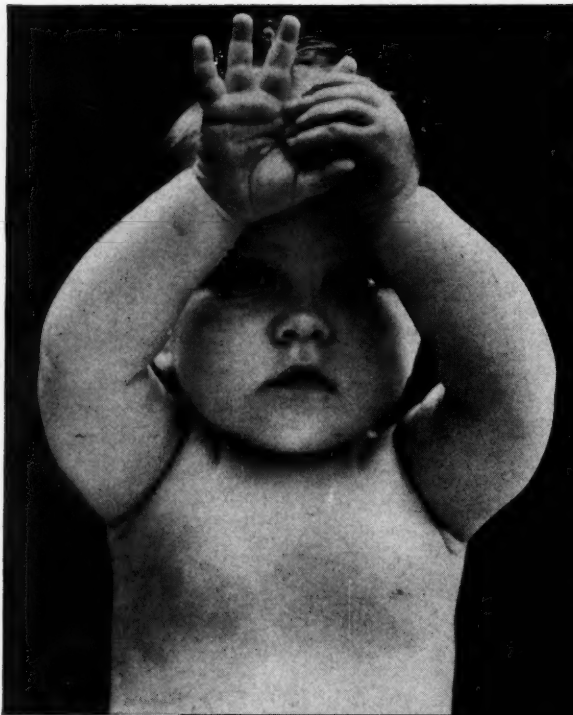
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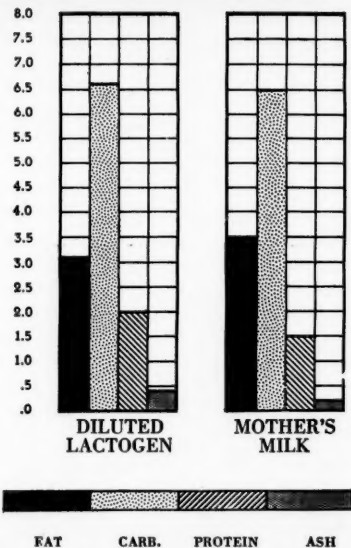
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